State of Rhode Island and Providence Plantations
Department of Health

DIVISION OF HEALTH SERVICES REGULATION

Authorization for Release of Confidential Health Care Information and Communications

I, _____, hereby release to the Rhode Island Board/Division of _____ any statements, reports, memos or medical records regarding my medical treatment that the Board/Division may require or subpoena of _____ (name of Health Care Provider).

The purpose for this release is to grant the Board/Division the ability to discover information relating to a confidential investigation.

I agree that the Board/Division of _____ may use this confidential information and communications at any hearing which the Board/Division may need to conduct relating to this investigation.

This authorization may be withdrawn by me at any time. Any revocation of this authorization must be transmitted by me in writing to the Board/Division.

I understand that these records and communications are protected by state and federal law.

_____ _____

Complainant Signature Date of Signature (MM/DD/YYYY)